# VBAC: A Medicolegal Perspective

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**KEYWORDS**

• VBAC • Trial of labor after cesarean • Malpractice
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History has always been a series of pendulum swings, and there is perhaps no better example in obstetrics than that of vaginal birth after cesarean (VBAC).

The phrase "once a cesarean always a cesarean" was coined by Edward B. Cragin in 1916.[1] Dr Cragin was referring to a very small proportion of pregnant women who were unable to deliver vaginally after several days in active labor and required cesarean delivery as a life-saving procedure. Despite the perils of surgery in that era, these women were not believed to be candidates for vaginal delivery in the future. Although this approach prevailed for more than 5 decades, the overall cesarean rate, and thus the repeat cesarean rate, remained low. When the rate of cesarean delivery in the United States was first measured in 1965, it was 4.5%.[2] During this period, surgery became much safer with the advent of modern surgical techniques, anesthetic agents, antibiotics, and blood transfusion.

The cesarean delivery rate began to rise in the 1970s. Consequently, patients and providers began questioning the paradigm of routine repeat cesarean deliveries. In 1981, a National Institutes of Health (NIH) Consensus Development Conference Panel on Cesarean Childbirth addressed this issue and recommended that more women who had undergone a previous cesarean delivery be offered a trial of labor.[3] The American College of Obstetricians and Gynecologists (ACOG) also concluded that carefully selected patients should be allowed a trial of labor after cesarean in its first publication on VBAC in 1982.[4]

With the advent of managed care in the 1990s, health maintenance organizations and insurers began to promote VBAC as a cost-saving measure; some even went so far as to mandate trial of labor after cesarean (TOLAC) and to withhold reimbursement for elective repeat cesareans. Because of these factors, VBAC rates steadily increased from 19.9% in 1990 to a peak of 28.3% in 1996.[5] Over the same period,

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the total cesarean delivery rate declined, from 22.7% to 20.7%, partly because of the decrease in repeat procedures.[5]

What happened next is well-known: the pendulum came back swiftly. VBAC rates declined dramatically over the next decade, to a low of 8.5% in 2006.[6] The cesarean delivery rate, meanwhile, has continued to rise unabated with the most recent estimate for 2008 reaching 32.3%.[7]

Several explanations have been ascribed to these trends. A landmark study published in the *New England Journal of Medicine* in 1996 by McMahon and colleagues[8] reported that major maternal complications were nearly twice as likely among women attempting a TOLAC compared with those who underwent an elective repeat cesarean. As more reports on adverse outcomes appeared after the McMahon article, liability pressure over the issue of VBAC grew. In response to this issue, ACOG revised its statement on VBAC in 1999, changing the tone of its language considerably.[9,10] Although the previous statement had encouraged a TOLAC for all women without contraindications, the new bulletin stated that women without contraindications should be "offered" a trial of labor. Even more importantly, they recommended that physicians and resources for emergency cesareans be "immediately available" to these patients. Unable to comply with these recommendations or unwilling to incur the risk of litigation, many physicians and hospitals across the country stopped offering TOLACs, limiting patient access to this option. In fact, approximately one-third of hospitals and one-half of physicians are no longer offering women a TOLAC.[11]

This past year, the NIH convened a Consensus Development Conference focused on the issue of VBAC.[11] The hope of the conference was that an updated review of the relevant literature would help inform the decisions made by both patients and providers when considering mode of delivery after cesarean. The panel specifically recommended that ACOG and the American Society of Anesthesiologists reassess the "immediately available" requirement, citing the low level of evidence for this recommendation and the limited access to trial of labor for women that has resulted. ACOG subsequently qualified but did not rescind the "immediately available" requirement.[12] Only time will tell the long-term effect of the conference on VBAC and cesarean rates, and ultimately where the pendulum will come to rest.

What are the fundamental reasons why many hospitals and physicians are no longer performing VBACs? The answer is undoubtedly risk of adverse outcomes and subsequent litigation. The recent NIH Consensus Conference Statement on VBAC acknowledged that the "current medical-legal environment—including provider perceptions of and experience with professional liability—exerts a chilling effect on the availability of trial of labor."[11] Perhaps an exploration of each of the medical and legal risks will shed light on this contentious issue.

As James R. Scott, MD,[13] aptly put in his editorial for the recent conference publication, "VBAC is essentially a uterine rupture issue." The greatest morbidity from TOLAC for mothers and infants clearly arises from uterine rupture. According to the recent conference statement, the risk of uterine rupture for women who undergo a trial of labor at term is 778 per 100,000 (0.778%), compared with 22 per 100,000 (0.00022%) for women who undergo a repeat cesarean at term.[11] Although several groups have tried to develop prediction models, no reliable method currently exists to predict which patients will experience a uterine rupture.[14,15] Even the factors commonly understood to increase the risk of uterine rupture, such as classical and low vertical uterine incisions, increasing number of prior cesarean deliveries, and induction of labor, are based on low-grade evidence according to the consensus panel.[11]

For patients who have a uterine rupture, what is the likelihood of neonatal death or neurologic injury? Approximately 6% of all uterine ruptures will result in perinatal death,